MISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

0047551 STATE FILE NUMBER

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 1407

FILED DEC 24 1964

DO NOT WRITE ON THIS STUB	AMENDED
VS 300 Rev. 4/59	
1	5117
2	0380
3	
4	0
5	1
6	
7	0
8	2
9	331x
10	
11	
12	3-0
13	1-0

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS: DATE AMENDED — ITEM NO. — INSTEAD OF — SHOULD READ — BY AFFIDAVIT OF DOCUMENT

1. PLACE OF DEATH
- a. COUNTY: Buchanan
- b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Joseph
- Length of stay in 1b: 5 Days
- c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: St. Joseph's Hosp.
- Inside Limits: Yes [X] No [ ]

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
- a. STATE: Missouri
- b. COUNTY: Gentry
- c. CITY OR TOWN: Stanberry
- Inside Limits: Yes [ ] No [ ]
- d. STREET ADDRESS (If outside, give location):
- Reside on Farm: Yes [ ] No [ ]

3. NAME OF DECEASED (Type or print): First: Richard Middle: G. Last: Kyger

4. DATE OF DEATH: Month: December Day: 11 Year: 1964

5. SEX: Male

6. COLOR OR RACE: White

7. Married [X] Never Married [ ] Widowed [ ] Divorced [ ]

8. DATE OF BIRTH: 2-8-1892

9. AGE (last birthday): 72 Years — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HR: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and state or country): Nodaway County

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Maxmillian Kyger

13b. MOTHER'S MAIDEN NAME: Mary Jane Brooks

14. NAME OF HUSBAND OR WIFE: Floreine Kyger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hospital Records Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		Interval between onset and death
IMMEDIATE CAUSE (a)	Cerebral vascular adcident with left hemiplegia	2 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Cerebral arteriorclerosis	month to year
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I(a)
(1) Arteriosclerotic heart disease with congestive heart failure
(2) Renal insufficiency secondary to #1

PART III. If deceased was female was there a pregnancy in last 90 days. [ ] Yes [ ] No [ ] Unknown

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 12/6/64, to 12/10/64 and last saw her/him alive on 12/10/64

Death occurred at 12:30 a m on the date stated above, and to the best of my knowledge, from the causes stated.

C.A. Potter, Jr., MD

22a. SIGNATURE Caryl C. Potter Jr. (Degree or title) M. D.

22b. ADDRESS 510 Francis, St. Joseph, Mo.

22c. DATE SIGNED 12/14/64

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: 12-11-1964

23c. NAME OF CEMETERY OR CREMATORY: Johnson Funeral Home

23d. LOCATION (City, town, or county): Stanberry (State): Missouri

24. FUNERAL DIRECTOR: Meierhoffer-Fleeman ADDRESS: St. Joseph, Mo.

25. DATE RECD. BY LOCAL REG.: Dec 22, 1964

26. REGISTRAR'S SIGNATURE: Mrs. Clade Goodell

(Licensed Embalmer's Statement on Reverse Side)

DEC 29 1954

Permit issued 12-11-64

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No. 1629

P. O. Address_____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.